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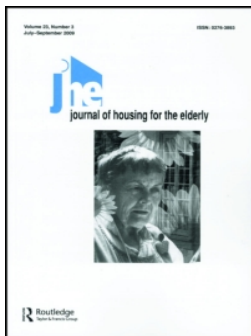
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Integrating Services for Older People in Aging Communities in The Netherlands: A Comparison of Urban and Rural Approaches

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ABSTRACT



The aim of this article is to discuss approaches to services integration for older people in urban and rural aging environments in The Netherlands, and the preliminary effects of these approaches on local aging conditions. In urban areas, services integration revolves around the creation of functional spatial hierarchy. In rural areas, the emphasis is on forging links between service providers. Outcomes for health and use of professional care services are similar. Outcomes for housing, informal care, and accessibility of services differ between urban and rural areas in ways that can be traced back to local aging conditions and elements of the specific approach to services integration used. In both urban and rural areas, much more could be done to connect formal programs to the lifeworlds of older dwellers.

KEYWORDS

Services integration;
integrated service areas;
urban and rural aging
communities; lifeworlds

Introduction

Over the years, efforts to support aging in place at the community or neighborhood level have been documented from within different corners of the social sciences, including environmental gerontology, health geography, and health services research (Ahrentzen, 2010; Bedney, Goldberg, & Josephson, 2010; Day, 2008; Evans, 2009; Greenfield, 2013; Greenfield, Scharlach, Lehning, & Davitt, 2012; Keating & Philips, 2008; Kietzman, Wallace, Durazo, Torres, Choi, Benjamin, & Mendez-Luck, 2012; Lawton, 1985; Lui, Everingham, Warburton, Cuthill, & Bartlett, 2009; Menec, Means, Keating, Parkhurst, & Eales, 2011; Phillips, Siu, Yeh, & Cheng, 2005; Smith, 2009; Tang & Pickard, 2008; Verma & Huttunen, 2015). This interdisciplinary literature has reported about interventions to improve the quality of the physical and social care environment (e.g., care-intensive forms of housing, adaptations to original homes,

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safe walking environments, meeting spaces, and strategies for social inclusion, amongst others) while also urging for the involvement of older dwellers through listening to their needs or building long-term collaborations (Everingham, Warburton, Cuthill, & Bartlett, 2012; Walsh & O'Shea, 2008; Warburton, Everingham, Cuthill, Bartlett, & Underwood, 2011). Contributions from health services research, in particular, have investigated the benefits and pitfalls of services integration for older people who live independently (Bedney et al., 2010; Brown, Tucker, & Domokos, 2003; Dubuc, Dubois, Raïche, Rokhaya Gueye, & Hébert, 2011; Glendinning, Coleman & Rummery, 2002; Greenfield, 2013; Kodner, 2002; Tang & Pickard, 2008). Broadly, services integration entails that providers of housing and medical and social care work together to improve existing and develop new neighborhood-based services, such as care on demand and support to informal carers and volunteers. Besides cost efficiency and synergy, the main objective of services integration is to prolong the time older people can stay in their familiar neighborhoods and to sustain their quality of life.

This article presents a reflection on the ongoing efforts to integrate services for older people in The Netherlands. In doing so, special attention will be paid to the similarities and differences between the approaches developed in urban and rural aging communities. The specific challenges for aging in place in urban and rural environments have been well documented. Urban environments offer a host of (obvious) advantages to older people, notably, better access to commercial services, and a wider range of public transport and housing options, although aging conditions in environments such as outer suburbs and degraded central areas can be disadvantageous as well (Phillips et al., 2005; Smith, 2009). Many older people in rural areas face a “double jeopardy” due to growing frailty and loss of services (Joseph & Cloutier-Fisher, 2005). On the other hand, successful community initiatives to support aging in place have been developed in rural communities (e.g., Horsten, 2008; Walsh & O'Shea, 2008)—although success stories are reported in cities as well (e.g., Warburton et al., 2011). As yet, we have not seen a systematic comparison of urban versus rural “approaches” to services integration, and more specifically the ways in which these approaches are aligned with and address the advantages and disadvantages associated with urban and rural aging conditions.

This article is based on a research project funded by The Netherlands Organisation for Health Research and Development (ZonMw), and was conducted between 2010 and 2013 by an interdisciplinary research team. The overall aim of this project was to identify different approaches to services integration in different aging environments and to offer a preliminary assessment of the impact of services integration on the well-being of older people living in these environments. Since approaches and also day-to-day practices to integrate services are still in development, the results presented here are explorative and descriptive. This article can be positioned in a tradition of older people's quality of life research (e.g., Oswald, Jopp, Rott, & Wahl, 2010; Puts, Shekart, Widdershoven, Heldens, Lips, & Deeg, 2007; Rioux & Werner, 2011). Phenomenology-inspired work on the lifeworld experiences of older people (Rowles, 1978, 1983, 1988) and in particular the

experiences of living in specific caregiving environments (Day, 2008) is a second source of inspiration.

We continue with a discussion on the general features of services integration for older people in the Netherlands and an overview of the mechanisms and impact of services integration documented in the wider international research literature. This is followed by a description of the research approach we used to investigate the specific features and elements of approaches to services integration in The Netherlands and the preliminary effects of these approaches in terms of quality of life outcomes. The subsequent two sections provide a detailed discussion of our findings, with a special emphasis on the differences between urban and rural aging communities.

Services integration in The Netherlands

In The Netherlands, like in other developed countries, the emergence of initiatives to integrate services for older people can be traced back to the 1980s, when awareness of population aging increased. This awareness set in motion a process of deinstitutionalization of elderly care, which started with the development of care-intensive forms of housing for the elderly (Singelenberg & Van Triest, 2009; Singelenberg, Van Triest, & Van Xanten, 2012). From here, mirroring international developments, more encompassing ideas about the development of age-friendly neighborhoods emerged, with increased attention to the linkages between providers (Singelenberg & Van Triest, 2009; Singelenberg et al., 2012). In the late 1990s, the term *integrated service area*, or ISA, was coined as an overarching concept.¹ In 2007, the so-called Social Support Act was introduced, which made municipalities responsible for the activation of citizens. Since then, the involvement of municipalities within ISAs has grown (Singelenberg & Van Triest, 2009; Singelenberg et al., 2012).

In 2012, hundreds of ISAs were registered with Dutch municipalities. Within the broader concept, three dominant models or approaches can be distinguished. The first of these revolves around the creation of functional spatial hierarchy. In this model, care and services are provided from a newly built services center located next to the local shopping center, and care-intensive forms of housing are offered in various clusters scattered around the area, all within walking distance from the services center. The second model is a more loose version of the first, with an existing nursing or care home as the central venue, and senior homes and commercial services within walking distance. We call this the “place-based” model. The third model does not set out from the built environment but from existing networks between providers of housing and medical/social care in a locality. In these cases, adaptations to the built environment (homes, activity centers, and public spaces) are made at a later stage (Singelenberg & Van Triest, 2009; Singelenberg et al., 2012).

¹The term ISA is also used by national-level knowledge centers for aging and housing issues in Denmark, Germany, Japan, Sweden, Switzerland, and the United States (see <http://www.isa-platform.eu/service/isa-integrated-service-areas.html>).

From the three levels of services integration discerned by Kodner (2002)—basic linkages between providers or care professionals, coordination between providers with respect to the planning of care and the development of guidelines, and disintegration of institutional boundaries between the fields of housing, health, and social care—it is the second level that best represents the state of play in most Dutch ISAs.² The wider literature further suggests that the rationale for services integration is especially strong in naturally occurring retirement communities (NORCs; e.g., Bedney et al., 2010; Greenfield, 2013; Greenfield et al., 2012). In NORCs, advancing age and frailty often intersect with low-income positions and a poor accessibility of the built environment, rendering elderly a higher chance of having unmet care needs. Indeed, most Dutch ISAs are developed in NORCs located in rural communities and in extension areas in cities built in the 1950s and 60s, called “postwar extension areas.”

Empirical research on the effects of services integration in the wider literature has yielded mixed results. Quantitative research has shown that services integration may reduce unmet care needs (Dubuc et al., 2011) and social isolation (Bedney et al., 2010) and may increase self-rated health among elderly across communities (Bedney et al., 2010). Further, there is some evidence about a positive impact on well-being and the number of hospital referrals (Kodner, 2002). Qualitative research by contrast has not found clear differences with respect to satisfaction with care between areas with and without services integration (Brown et al., 2003). Unfortunately, services integration can be linked to aging in place only in very general terms. It is highly difficult to work out how, in light of complex local geographies and histories, services integration programs or specific elements of these programs lead to changes in (domains of) well-being (Brown et al., 2003; Glendinning et al., 2002). Therefore, attention has also been drawn to the social learning processes that take place in areas with services integration, through which, in the long term, social transformation can occur (Bedney et al., 2010). The most promising route into effectuating aging in place is to connect policies and practices of services integration to a wider knowledge of the aging community (Greenfield, 2013; Greenfield et al., 2012). This can be achieved when links and relations are improved not only between service providers, but also between leading professionals and older dwellers, and between older dwellers themselves (Greenfield, 2013; Greenfield et al., 2012). In the vocabulary of humanistic geographers, this is about fostering “insideness”: a profound geographical knowledge of the local environment and community, and, in this case, the aging experiences and care needs of local older dwellers (Relph, 1976; see also Cresswell, 2013).

²Recent institutional changes in the field of health care in The Netherlands hold the potential to carry the ISAs to the third level. Since 2015, municipalities are responsible for the provision of care and support to vulnerable populations living independently or in assisted living facilities. Faced by major budget cuts, the municipalities are putting pressure on care providers to join forces with other providers. As a consequence, local integrated care teams are mushrooming in neighborhoods and villages, and renewed attention is being paid to the development of alternative care-intensive forms of housing.

Table 1. The 10 selected ISAs.

ISA	Urban/ Rural	Type of ISA	Total population living within ISA boundaries	Percentage aged > 65	Percentage of rental homes	Percentage of elderly who continued to live independently after 5 years ^a
<i>Leeuwarden, Bilgaard</i>	Urban	Functional hierarchy	5,950	25.7	71.3	84.8
<i>Hooogeveen, Krakeel</i>	Urban	Functional hierarchy	5,025	14.2	42.5	68.8
<i>Hengelo, Berflo Es</i>	Urban	Network- based	20,705	20.4	54.6	60.7
<i>Didam, Meulenvelden</i>	Rural	Place-based	16,680	17.8	35.1	67.3
<i>Dronten</i>	Rural	Place-based	13,670	17.8	50.9	65.3
<i>De Bilt, Dorp West</i>	Rural	Network- based	5,955	20.4	10.5	54.0
<i>Zeevang, De Verbinding</i>	Rural	Network- based	6,310	14.7	21.7	62.1
<i>Middelburg, Noordoost</i>	Urban	Functional hierarchy	9,510	18.5	39.5	80.4
<i>Breda, Hoge Vucht</i>	Urban	Functional hierarchy	15,520	18.7	67.1	74.5
<i>Helden-Panningen</i>	Rural	Network- based	13,550	17.9	30.3	63.6

Note. ISA = integrated service area.

^aThis column reflects the number of older people aged 80 years or over who lived independently in 2008 as a proportion of the numbers of older people aged 75 years or over living independently five years before, in 2003 (Source: ABF Research, 2008).

In the remainder of this article, we will discuss the ways in which ISAs are developed in urban and rural aging communities, and we will draw preliminary conclusions about whether these developments are indeed improving aging conditions in these communities. We do this by discussing the specific elements of services integration, differences in outcomes for various domains of well-being, and our assessment of whether the specific approaches to services integration taken in urban and rural areas have had a substantial effect on these outcomes. First, we will discuss our research approach.

Research approach

Selection of ISAs

The ISAs in this research were selected by a national-level knowledge center for housing issues, Stichting Experimenten Volkshuisvesting. This selection was guided by the contacts that were established with ISA developers and professionals in previous initiatives taken by the knowledge center, not by objective criteria formulated by the researchers. Consequently, the selection does not represent an “ideal” range of ISAs on the Dutch urban–rural continuum. For example, the sample does not include ISAs in larger cities such as Amsterdam or Rotterdam; with 175,000 inhabitants, Breda is the largest city in the sample. Instead, the selection was based on the level of implementation and the innovative value of local practices. Table 1 presents the names and the

most important information for the 10 selected ISAs. For the sake of convenience, the names of the ISAs are accompanied by the names of the municipalities in which they are located. The actual ISAs cover only one or two neighborhoods or one or two core villages, plus a number of smaller settlements.

Table 1 shows that, with the exception of Hengelo, the model based on functional hierarchy was applied in all urban ISAs, but in none of the rural ISAs. This is not a coincidence: Many ISAs in urban settings were developed as part of broader urban restructuring programs with ample funds available for neighborhood renewal. In villages, it may make more sense to use existing venues to colocate services and to prioritize investments in homes that are suitable for aging in place.

Data sources and data analysis

All older people aged 70 and over living independently in the 10 selected ISAs received a letter with information about the research. In this letter, respondents were asked to complete a short six-question survey on issues of physical and mental health. This survey was a shortened version of the Groningen Frailty Indicator (GFI; Peters, Boter, Buskens, & Slaets, 2012). Overall, the response to this letter was about 45% ($N = 5,414$). The use of dichotomized scores on these questions made it possible to define seven levels of frailty. These levels were used to select samples of 150 respondents in each ISA ($N = 1,500$) that were representative of the population in each ISA and that included a significant and representative share of frail older people.

Both quantitative and qualitative data collection methods were used. The literature on mixed methods (see Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005) suggests various ways to combine quantitative and qualitative methods in a single study. This research follows the idea that they are best used for complementary purposes, resulting in a broader and potentially more insightful perspective (Hanson et al., 2005; Sale, Lohfeld, & Brazil, 2002). The first data source was a custom-made survey that included a broad range of quality of life indicators, ranging from physical and mental health and satisfaction with services to the quality of support networks. The survey was composed of the Groningen Frailty Indicator (Peters et al., 2012), questions from a survey on informal care used by The Netherlands Organisation for Health Research and Development (ZonMw), and questions from a survey on housing circumstances (WoON), used by the Ministry of Housing, Spatial Planning and the Environment (2009). In each ISA, specific survey questions were added about the commercial and social services available in the areas. To be able to compare urban and rural ISAs, the survey data were analyzed by means of chi-square tests.

At the end of the survey, respondents were asked about their willingness to participate in a follow-up narrative interview. In each ISA, 36 respondents from this subgroup were selected for an interview, yielding a total of 360 respondents. The interviews started with the interviewer asking a so-called Single Question Inducing Narratives (SQUIN; Wengraf, 2001): "Could you tell us how an ordinary day in your life looks like?" The idea here was to invoke a respondent's storytelling mode

(Bruner, 2010), allowing the respondent to set a specific conversation agenda, although an interview guide was used as a backup instrument to retain focus. Transcriptions of the interviews were segmented into coherent fragments, or narratives. These narratives were coded using a set of coding categories (again, physical and mental health, and so forth). Coding categories and combinations of coding categories were used to search the database of narratives.

In addition, we analyzed strategic and policy documents and conducted expert interviews with professionals from housing, care, and welfare providers. This allowed us to make a comparison of “defining elements” of ISAs. These defining elements were identified by the knowledge center for housing issues in close consultation with local ISA developers and professionals (Singelenberg & Van Triest, 2009). Distinguishing the different defining elements of each ISA, in turn, allowed us to identify urban–rural differences in the ways in which ISAs are developed.

Defining elements of urban and rural ISAs

The 10 ISAs in the sample consist of program agreements involving the local municipality and two or three key providers in a coordinating role. On the basis of our interviews, it would appear that coordinating actors in rural ISAs are more successful in engaging each other and other providers than actors in urban ISAs are (De Kam, Damoiseaux, Dorland, Pijpers, Van Biene, Jansen, & Slaets, 2012a, 2012b). There are two reasons for this. First, the fact that many urban ISAs are part of wider urban restructuring programs often means that the funding that is actually available for services integration depends on bureaucracies, considerations of equal treatment, city-level or regional development strategies, and so on. Second, in urban ISAs often multiple providers are active, and even if these providers are not in direct competition with each other, they certainly have different strategies and priorities. Two notorious integration problems in areas with more than one provider are the management of information desks or back offices, and the organization of care on demand during nighttime (De Kam et al., 2012a, 2012b).

Despite this, the only ISA in our sample where program management really did not work out well is in Zeevang, where multiple municipalities tried to support aging in place in a number of smaller villages and a stretch of relatively isolated countryside. The program was discontinued in 2012 after several changes in local government had occurred, including the replacement of an alderman who was strongly committed to the program.

Tables 2 and 3 provide an overview of the most important defining elements of services integration offered in the selected ISAs. The defining elements are divided into “hardware” and “software,” with hardware elements comprising interventions in the built environment, such as care-intensive forms of housing and activity centers, and software elements the available services, ranging from professional primary health-care services to a local volunteer center.

In many respects—acknowledging the limitations of this basic way of ranking—overall, the rural ISAs in our sample appear to have a more complete offer of defining

Table 2. “Hardware” elements: Homes, functional spaces, and the built environment.

Defining Elements	Urban ISAs						Rural ISAs					
	Le	Ho	He	Mi	Br	Total	Di	Dr	Bi	Ze	HP	Total ^b
<i>Fitting/suitable rental homes</i>	xx ^a	xx	xx	xx	x	90	xx	x	xx	xx	x	80
<i>Fitting/suitable owner-occupied homes</i>		xx			xx	40		xx	xx	xx		60
<i>Alternative care-intensive forms of housing</i>	xx	xx	x	xx	x	70	xx	xx	x	xx	x	70
<i>Safe and walkable living environment</i>	xx	xx	xx	xx	xx	100	xx	xx	xx	xx	xx	100
<i>Meeting space/activities center</i>	xx	xx	x	xx	x	70	xx	xx	xx	xx	xx	100
<i>Clustered medical facilities</i>	xx		x			30	xx	xx	xx		xx	80
Total ^b	83	83	58	66	58	66	83	92	92	83	66	82
<i>Fitting/suitable rental homes</i>	Number of fitting/suitable rental homes for older dwellers, including life-course friendly homes. Existing stock of homes plus new build homes, preferably divided into categories of “fitness/suitability.”											
<i>Fitting/suitable owner-occupied homes</i>	Number of fitting owner-occupied homes for older dwellers, including life-course friendly homes. Existing stock of homes plus new build homes, preferably divided into categories of “fitness/suitability.”											
<i>Alternative care-intensive forms of housing</i>	Number of alternative care-intensive forms of housing, preferably small-scale.											
<i>Safe and walkable living environment</i>	Accessibility of public space, including traffic safety, quality and maintenance of main walking routes, and street lighting.											
<i>Meeting space/activities center</i>	Central location (e.g., in local community building) where older dwellers can obtain information and help and where activities are organized.											
<i>Clustered medical facilities</i>	GPs, pharmacy, physiotherapy, and other care providers located in one building or cluster of buildings. Presence of primary medical care in the neighborhood.											

Note. Le = Leeuwarden; Ho = Hoogeveen; He = Hengelo; Mi = Middelburg; Br = Breda; Di = Didam; Dr = Dronten; Bi = De Bilt; Ze = Zeevang; HP = Helden-Panningen.

^aElements still in development are marked once (x); elements fully developed are marked twice (xx).

^bTotals equal the percentage of marks of the total number of marks possible: 12 per ISA; 10 per element for all ISAs.

elements. With respect to hardware elements, the most telling difference concerns the availability of clustered medical facilities. With respect to software elements, the most telling differences concern the availability of a local care team, and advisory and information services. For advice on making adaptations to original homes, this is not surprising given the fact that home ownership is more prevalent in rural ISAs (Table 1). The other differences can be explained by the emphasis on forging links between providers in rural ISAs: The only urban ISA where a local care team is operational is Hengelo, which is also the only network-based urban ISA.

Helden-Panningen is the only ISA where concerted efforts have been made to include the local community, including older dwellers (De Kam et al., 2012a, 2012b), in both the formal agreement and in the implementation of (software) elements. The village has a thriving local volunteer center from which various forms of support are available, complementing formal care services. These achievements can be traced back to the successful adoption of the network approach and the dedication of the program manager. The urban ISAs of Breda, Leeuwarden, and Hengelo have participated in a national-level intervention program to encourage elderly to voice unmet care needs. In all ISAs, the project on which this article is based provided the first encompassing overview of older people’s experiences with aging and care.

Table 3. “Software” elements: Care and social services.

Defining Elements	Urban ISAs						Rural ISAs					
	Le	Ho	He	Mi	Br	Total	Di	Dr	Bi	Ze	HP	Total ^b
<i>Local care team offering integrated care services</i>			xx ^a			20			xx			20
<i>Cooperation between local care team and providers of primary health care</i>			xx			20			x		xx	30
<i>Professional advisory services</i>	xx		xx			40		x	xx	xx	xx	70
<i>Local information/service desk</i>		xx	x	xx	x	60	xx	xx	xx	xx	xx	100
<i>Home care on demand</i>	xx	xx	x	xx	xx	90		xx	xx	xx	xx	80
<i>Transportation services</i>	xx	xx	xx	xx	xx	100	xx	xx	xx	xx	xx	100
<i>Advice on adaptations to the home</i>			xx			20	x	xx	xx		x	50
<i>Local volunteer center</i>	xx	xx	xx	xx	xx	100	xx	xx	xx		xx	80
<i>Support of volunteer help</i>	xx	xx	xx	xx	xx	100	xx	xx	xx	xx	xx	100
<i>Offer of leisure activities</i>	xx	xx	xx	xx	xx	100	xx	xx	xx	xx	xx	100
<i>Home services</i>	xx	xx	xx	xx	xx	100	xx	xx	xx	xx	xx	100
Total	64	64	91	64	60	68	60	77	95	64	86	75
<i>Local care team offering integrated care services</i>	Local team of professionals from different care providers (e.g., nurses, home care staff) but with its own financial budget.											
<i>Cooperation between local care team and providers of primary health care</i>	Meeting routine involving local care team and providers of primary care in the neighborhood.											
<i>Professional advisory services</i>	Professional, independent advice on all matters related to housing, care, and welfare of older dwellers.											
<i>Local information/service desk</i>	Centrally located information and service desk where older people can obtain information and advice from all parties and providers working in the neighborhood.											
<i>Home care on call</i>	Available 24/7..Comprises scheduled as well as unscheduled care (emergency care). Rapid response time.											
<i>Transportation services</i>	Public transport, local taxis, and specialized transportation services for older people (usually provided at municipal or regional level).											
<i>Advice on adaptations to the home</i>	Advice on adaptations to original homes for older homeowners. Adaptations include home automation, stair elevators, adapted beds, personal alarm systems, and additional handles and grips.											
<i>Local volunteer center</i>	Coordination of demand for volunteer care and offer of volunteers (usually provided at municipal or regional level).											
<i>Support of volunteer aid</i>	Information to volunteers, discussion groups, occasional or more structural replacement of tasks by others (usually provided at municipal or regional level).											
<i>Offer of leisure activities</i>	Sports, craft and hobby classes, and day-care activities.											
<i>Home services</i>	Groceries, handyman service, meal service.											

Note. Le = Leeuwarden; Ho = Hoogeveen; He = Hengelo; Mi = Middelburg; Br = Breda; Di = Didam; Dr = Dronten; Bi = De Bilt; Ze = Zeevang; HP = Helden-Panningen.

^aElements still in development are marked once (x); elements fully developed are marked twice (xx).

^bTotals equal the percentage of marks of the total number of marks possible: 22 per ISA; 10 elements for all ISAs.

Linking outcomes to approaches to services integration

Housing situation

As can be seen in Table 4, respondents in rural ISAs significantly more often feel that their home is not suitable for aging in place. This can be explained, first, by the fact

Table 4. Urban–rural differences in adapted housing.

	Urban–Rural Classification		<i>p</i> value
	Urban (<i>N</i> = 791)	Rural (<i>N</i> = 753)	
Housing Situation ^a			
Home suitable for aging in place	72.30	64.90	.002
Home adapted for older people	36.00	30.90	<i>ns</i>
Sufficient alternative housing options (%)	87.60	77.70	.000

Note. ^aMeasured on a scale from 1 to 10.

that a large share of rural homeowners do not live in adapted homes.³ While Table 4 shows no significant difference between respondents in urban and rural ISAs on this issue, since home ownership in rural ISAs is much higher, it can be concluded that many rural homeowners have not made adaptations to their homes. This situation occurs in spite of the fact that advice on how to organize and fund adaptations to original homes is available in most rural ISAs. Research has shown that this kind of advisory service has a positive impact on housing outcomes for older people (Burgess & Morrison, 2016), which begs the question why people do not seek advice. In the village of Dronten, the interviews with professionals revealed that many people enter waiting lists for senior housing long before they are in any need to move, without properly considering making adaptations. Apparently, this is caused by an anxiety that, should the time come when they can no longer stay in their original homes, they would have nowhere to go. This is confirmed by the data in Table 4 Respondents in rural ISAs significantly more often think that there are fewer alternative housing options available in the wider neighborhood. However, as can be seen in Table 2, rural ISAs have made substantial investments in the development of alternative care-intensive forms of housing, and perceived scarcity is higher than actual scarcity. What seems to be the case here is that older people anticipate relocation because they lack awareness about services that are available to support them to stay in their original homes (see Tang & Pickard, 2008). At the time of this writing, this situation was back-firing for older people in Dronten, where waiting lists for senior housing were very long. The situation is further complicated by the fact that professionals in ISAs have a limited overview of the number of privately owned homes that are in (urgent) need of adaptation (De Kam et al., 2012a, 2012b).

The consequence of this “double jeopardy” is visible in the data presented in the right column of Table 1 At the end of a five-year period of time, from 2003 to 2008, a larger share of older people continued to live independently in urban ISAs compared to rural ISAs. Like in the wider literature, it very is difficult to establish causal relationships between program interventions and outcomes, and in this research especially because some of the programs started only toward the end of this five-year period. Still, it would seem that the lack of adapted homes and the

³In both rural and urban ISAs, about 30% of respondents live in adapted homes (De Kam et al., 2012a, 2012b).

Table 5. Urban–rural differences in health.

	Urban–Rural Classification		<i>p</i> value
	Urban (<i>N</i> = 791)	Rural (<i>N</i> = 753)	
Health			
Feeling fit <i>M</i> (<i>SD</i>) ^a	6.82 (1.29)	7.01 (1.22)	.001
Frailty <i>M</i> (<i>SD</i>) ^b	2.64 (2.08)	2.62 (2.15)	<i>ns</i>
Limitations as a result of physical problems (%)	59.80	57.60	<i>ns</i>
One or more chronic illness (%)	59.00	56.80	<i>ns</i>
Vision problems (%)	25.00	25.20	<i>ns</i>
Hearing problems (%)	35.10	35.70	<i>ns</i>
Ever experienced mental problems <i>M</i> (<i>SD</i>) ^c	0.43 (0.74)	0.55 (0.84)	.002
Mental problems at this moment <i>M</i> (<i>SD</i>) ^c	0.09 (0.29)	0.15 (0.44)	.006
Feeling down in last 4 weeks <i>M</i> (<i>SD</i>) ^d	4.16 (1.02)	4.18 (0.94)	<i>ns</i>
Feeling calm in last 4 weeks <i>M</i> (<i>SD</i>) ^d	1.38 (1.17)	1.36 (1.28)	<i>ns</i>
Feeling happy in last month <i>M</i> (<i>SD</i>) ^d	1.34 (1.08)	1.42 (1.04)	<i>ns</i>

Note. ^aMeasured on a scale from 1 to 10.

^bMeasured on a scale from 1 to 15.

^cMeasured on a scale from 0 to 3, ranging from *not at all* to *very much*.

^dMeasured on a scale from 0 to 5, ranging from *all the time* to *never*.

perceptions about suitable alternative housing options constitute a major barrier to aging in place in some rural ISAs.⁴ This implies there is considerable scope to improve awareness raising and information provision in these ISAs.

Physical and mental health

Table 5 shows the differences in physical and mental health between older people in rural and urban areas. With regard to physical health, we found no significant differences in minor and major physical problems, chronic illnesses, or frailty. Nevertheless, respondents in rural areas reported feeling slightly more fit than those in urban areas. With regard to mental health, again no significant differences were found even though rural older dwellers have slightly more psychological problems. No clear-cut explanations for these particular findings emerged in our data. It might be possible that fitness in urban ISAs is lower because built environments in these ISAs are less inviting to older people, who consequently do not go out as much:

Growing old isn't always easy. Stretches of pavement, walking a long stretch of pavement isn't always pleasant. Not just in this area but in the whole of Hengelo, especially in the vicinity of bus stops or entrances of senior homes, pavements are not often enough swept and cleaned. Occasionally I hear people say, "I'm not getting out the door anymore." (Male respondent, city of Hengelo)

In rural communities, it may be less common to accept or voice mental problems, as a consequence of which thresholds to seek professional help may be higher:

⁴Didam is the only rural ISA in our sample where elderly are well aware of alternative housing options in their village. The reason for this is that this particular ISA was initiated by a housing association, which, in the course of half a decade, has made many visible investments in the senior housing stock in the village.

Table 6. Urban–rural differences in care and services.

	Urban–Rural Classification		<i>p</i> value
	Urban (<i>N</i> = 791)	Rural (<i>N</i> = 753)	
Care and Services			
General practitioner (%)	73.90	73.40	<i>ns</i>
Specialist for physical problems (%)	50.90	45.50	.036
Specialist for mental problems (%)	1.30	1.60	<i>ns</i>
Social worker (%)	1.60	1.50	<i>ns</i>
Physical therapist (%)	18.40	22	<i>ns</i>
Nurse (aide) home care (%)	6.80	9.10	<i>ns</i>
Nurse practitioner (%)	6.50	10	.011
Receiving a sufficient amount of those forms of care that are most needed (%)	96.50	96.10	<i>ns</i>
Good collaboration of care professionals (%)	85.80	81.50	<i>ns</i>
Receiving informal care (%)	15.50	21.10	.006
Receiving volunteer care (%)	3.30	4.80	<i>ns</i>
Providing informal care (%)	29.40	34.50	.037
Accessibility of commercial services <i>M</i> (<i>SD</i>) ^a	3.52 (1.00)	3.41 (1.19)	<i>ns</i>
Accessibility of social services <i>M</i> (<i>SD</i>) ^b	2.44 (0.90)	2.58 (0.87)	.000

Note. ^aMeasured on a scale from 0 to 4, ranging from *not at all* to *very much*.

^bMeasured on a scale from 0 to 3, ranging from *not at all* to *very much*.

Well, I just go on and I'm very hard on myself. Not a complainer, I don't like complaining. Can't stand it in other people. That's not like me. I like to do things the way I always do them. Even if I have to crawl. I don't like to go to bed when I'm ill, no. (Male respondent, village of Dronten)

Care and services

With regard to professional care services, shown in Table 6, significant differences were found for the use of specialist hospital doctors and nurse practitioners. Although effect sizes are small, we see that rural dwellers pay fewer visits to hospital doctors than their urban counterparts do. This may be because of the travel and effort involved, but it is also possible that the higher use of nurse practitioners in rural areas, in combination with the use of other care professionals, serves to detect and address emerging health problems early. In addition, respondents in both aging environments are satisfied with the availability of the forms of care that suit their needs, and with cooperation between care professionals. This is an indication that area-specific approaches to services integration are successful, although Brown et al. (2003) have argued that elderly living in areas with services integration assess the quality of care without considering processes of services integration per se, as these are not very relevant to their daily lifeworld. As in previous research (Milligan, 2000), elderly voice a strong appreciation of individual care professionals:

They put on and put out support stockings. One comes in the morning and the other one in the evening. I like that very much. It's enjoyable. They drink a cup of coffee with me, or something like that. (Female respondent, city of Middelburg)

Table 6 further shows there are no differences with respect to volunteer support, but older rural dwellers do receive significantly more informal care—measured as

care provided by family members, friends, *and* neighbors—than their urban counterparts. This confirms previous research in The Netherlands, which concluded that older people in less urbanized areas get more informal help (Timmermans et al., 2001). When looking at the sorts of informal care received, rural dwellers receive more help for financial administration, such as clarifying letters and bills, helping out with online banking, and bookkeeping. A possible explanation for this finding is related to income composition: Older rural dwellers are more likely to have an income consisting only of a basic pension (De Kam et al., 2012a, 2012b). As a consequence, they can use some help in applying for specific benefits and tax deductions, for example.

Volunteer work and informal care seem to be reciprocal activities, partly because a degree of reciprocity is expected, and because it allows people to engage in meaningful interaction:

I am satisfied with my life, I really don't have complaints. Nobody is coming to fetch you, you have to look for it yourself. I have always done volunteer work, it's an easy way to get to know people. (Male respondent, village of Helden-Panningen)

The survey results show that about 30% of the respondents provide informal care themselves, with the exception of the rural ISA of Helden-Panningen, where informal care has likely been substituted by volunteer work. Informal care varies from getting groceries for direct neighbors to cooking for the wider neighborhood:

I cook every day, that is to say ... I have volunteered for 45 years, cooking buffets, salads and soups, and I am still cooking to bring people in the street together... There are people living in this neighborhood who never tasted homemade pea soup before! (Female respondent, city of Hengelo)

To date, however, older people's own possible contributions to the local community are not fully recognized by local policymakers and service providers, and are therefore largely missing from services integration programs.

Table 6 also contains information about the accessibility of services. For commercial services, the observed difference in accessibility between urban and rural ISAs is not statistically significant.⁵ For social services, the difference is significant, but still relatively small. Interestingly, while the two most urbanized ISAs (Breda and Leeuwarden) are the most accessible, accessibility in two other urban ISAs (Middelburg and Hoogeveen) is rather poor.⁶ We also see a poor accessibility in Zeevang. This is the case because the small catchment area prohibits feasible investments by service providers. In the other rural ISAs, levels of social services are more or less similar to those in urban ISAs. Further, the accessibility of services

⁵The research on which this article is based also measured the accessibility of commercial and social services in terms of walking distance, using GIS technology (see De Kam et al., 2012a, 2012b). Interestingly, in some respects, the outcomes for accessibility yielded in this way differed from the accessibility perceived by elderly, showcasing the importance of listening to elderly's experiences of daily life in areas with services integration.

⁶Measured on a 4-point Likert scale, the average score on accessibility of social services in Hoogeveen ranked 1.9. The other ISAs ranked between 2.3 (Middelburg, Zeevang) and 2.8 (Breda, Leeuwarden).

Table 7. Urban–rural differences in attachment to place.

	Urban–Rural Classification		<i>p</i> value
	Urban (<i>N</i> = 791)	Rural (<i>N</i> = 753)	
Attachment to Place ^a			
Attractiveness of neighborhood <i>M</i> (<i>SD</i>)	2.98 (0.67)	3.10 (0.66)	.000
Connectedness to neighborhood <i>M</i> (<i>SD</i>)	2.53 (0.87)	2.65 (0.85)	.009

Note. ^aMeasured on a scale from 0 to 4, ranging from *not at all* to *very much*.

is high as well, which (again) suggests that built environments in rural ISAs are inviting to older people. All in all, we can conclude that rural ISAs have been successful in sustaining the level of services and in adapting built environments, with the exception of Zeevang.

In the ISAs in Hoogeveen and Middelburg, no general practitioner is available within walking distance. In The Netherlands, this is not uncommon for postwar extension areas: Most general practitioners are located either in city centers and adjacent (prewar) neighborhoods, or in newer extension areas, leaving intermediate areas built in the 1950s and 60s underserved (Den Draak & Van der Knaap, 1992).⁷ Fortunately, in the other postwar extension areas in our sample (Leeuwarden, Hengelo, and Breda) a general practitioner is available. In these ISAs, both the level and the accessibility of social services are considered adequate. This in turn can be seen as an effect of current and previous efforts to improve services provision in these areas.

Finally, in the interviews older people indicate that accessibility in their daily life also implies being able to get from their neighborhood to the city center. In these interviews, some concerns were raised about infrequent bus connections to city centers (De Kam et al., 2012a, 2012b). This underscores the importance of embedding ISAs within wider urban development strategies and involving the municipality in a coordinating role.

Place attachment

From both the survey (Table 7) and the interviews, we can conclude that respondents in rural ISAs find their neighborhood more attractive and feel more connected to their neighborhood than their urban counterparts. Nevertheless, all of the neighborhoods and villages included in this research are important frames of reference for older dwellers. In urban ISAs Hengelo and Hoogeveen, the trees, parks, gardens and other green spaces in the neighborhood are much appreciated. In the rural ISAs as well as in the medium-sized city of Middelburg, older people value the peace and quiet of the countryside. In Helden-Panningen and Didam, they appreciate the “village-like” character of the place:

⁷The ISA in Middelburg is not strictly located in a postwar extension area, but comprises a number of prewar and postwar neighborhoods.

Table 8. Urban-rural differences in social contacts.

	Urban–Rural Classification		<i>p</i> value
	Urban (<i>N</i> = 791)	Rural (<i>N</i> = 753)	
Social Contacts ^a			
Family <i>M</i> (<i>SD</i>)	2.80 (0.86)	2.80 (0.88)	<i>ns</i>
Friends <i>M</i> (<i>SD</i>)	2.18 (0.99)	2.19 (0.97)	<i>ns</i>
Neighbors <i>M</i> (<i>SD</i>)	2.88 (1.01)	2.71 (1.01)	.000
Clubs <i>M</i> (<i>SD</i>)	1.51 (1.39)	1.66 (1.36)	.037

Note. ^aMeasured on a scale from 0 to 4, ranging from *never* to *daily*.

We are village people, not that we always lived in this part of the village [ISA] but we were born and raised here, so ... we know what it is like! Besides, village life has a lot to offer, many traditional things, the traditional rifle club, banner waving, and so on. And we are part of a church community, always something going on there. (Male respondent, village of Didam)

In Dronten, a village created in the 1950s and 60s on newly reclaimed land, older people are very proud of their personal contribution to the making of the local community in their working years:

We arrived in 1962 and established a pharmacy. We started all over again here. The idea of such a whole new village in the making sounded appealing to us. And we did it! (Female respondent, village of Dronten)

It is our impression that policies and practices of services integration could connect much more to the strong attachment to place articulated by older dwellers. In Dronten, for example, some older people who moved to senior housing are not used to the higher densities within the ISA and miss the views they had when they were living on the outskirts of the village. In discussions with elderly in Dronten, it was suggested to organize small-scale bus excursions allowing people to continue to experience the “polder” landscape. In Breda and Leeuwarden, many older people are struggling with cultural diversity in their neighborhoods:

I think, and there are more people here who think the same but do not say it, that there are too many foreigners living here. And when I see I have a 30-year-old grandson who just cannot find an apartment, he and his girlfriend. And they are in the best houses ... I can't stand them for that. (Female respondent, city of Breda)

In these two cities, the offer of social activities could be extended to facilitate contact between older people and neighborhood dwellers from various cultural backgrounds.

Although the data do not clearly distinguish between different forms of place attachment, it certainly seems that attachment can fuel the willingness to contribute to the local community, especially in rural areas (see Vermeij & Steenbekkers, 2015). For example, the volunteer center in Helden-Panningen is successful not

because it is an element of an ISA, but because the local village culture encourages volunteer work.

Social contacts

While there are no significant differences in the frequency of contacts with family members and friends, in urban areas respondents have significantly more contact with their neighbors than do their rural counterparts (see [Table 8](#)). This finding contrasts with previous research which concluded that in general, people in rural areas have more contact with neighbors (Steenbekkers et al., 2006), yet it resonates the idea that older rural dwellers have less contact with fellow villagers than do younger rural dwellers (Steenbekkers, Simon, & Veldheer, 2015). At least two explanations can be given. First, urban aging environments offer more chances to meet neighbors, as is evidenced in the interviews, for example in shared spaces in high-density apartment buildings:

We get on well. We live with eight people on this floor, and we all know each other. When someone is ill, for example with the flu, we are always there for each other. This does not mean you have to be together the whole day. Yes, they are there for me and I am there for them, we are neighbors, you see. (Female respondent, city of Leeuwarden)

More importantly, as can be seen in [Table 8](#), older people in rural ISAs have more social contacts through membership in local clubs and societies, ranging from choirs and sport clubs to historical societies:

Tonight there is another meeting of the club and I have to be there. I just make coffee for the people attending, that's all. I like to do that, every week, again next week. (Female respondent, village of Zeevang)

This corresponds with the findings of previous research (Knol, 2002). It would seem that in rural ISAs, social contacts obtained through club membership are a substitute for contacts with direct neighbors: For people who know many fellow villagers, contact with direct neighbors may be less important.

Conclusions

This article used mixed methods to investigate approaches to services integration for elderly populations developed in Dutch cities and villages, and the way in which these approaches address specific challenges for aging in place. Thus far, the health services research literature has looked at differences between areas with and without services integration. This article departs from a geographical perspective, highlighting the idea that services integration programs are implemented in aging communities with distinct local geographies, with the ultimate aim to support older people with unique personal geographies who are living independently in these communities. We investigate to what extent approaches to services integration are “aligned” with these local and personal geographies, and whether these approaches are effectively addressing local aging conditions.

We have shown that, first of all, there is a relation between the three “models” of services integration—or rather of Integrated Service Areas—that can be distinguished in The Netherlands, and the type of aging environment in which they are developed. This area-based “specialization” makes good sense from a practical, organizational point of view: In cities, more funds are available for neighborhood renewal and the creation of new venues; in villages, using existing venues and deepening links between providers may be the most feasible. Yet in some respects the approaches are not well aligned with local aging conditions. In urban ISAs, the relatively strong emphasis on housing and the built environment somewhat obscures the difficulties in getting higher numbers of competing providers to work together. Moreover, in ISAs developed in postwar extension areas, there is a chance that essential care services are still missing. In rural ISAs, the relative emphasis on forging links does not so much result in a lack of alternative housing options, but in a lack of attention to awareness raising among elderly about these options. However, this may be a problem in rural ISAs regardless of the approach or model used, as older rural dwellers generally anticipate relocation rather than aging in place.

No striking differences were observed between urban and rural approaches to services integration and their effect on health outcomes and use of professional care services. Yet, it may be advisable for urban ISAs to continue to pay attention to the opportunities for physical activity offered by built environments, and for rural ISAs to be receptive to psychological problems, even if these are not expressed openly.

Interesting differences were found with respect to the nature of social contacts: Neighbors matter slightly more for urban elderly, and local clubs and societies mean more to rural elderly. Yet, with respect to the issues of connectedness to neighborhoods and informal care, the importance of local community and village culture in rural ISAs really stands out. In these areas, many older people do not only receive but also provide informal care. This implies there are plenty of opportunities for exploring new combinations between formal and informal care in rural ISAs that involve older people both as recipients and providers of care. However, to date, Helden-Panningen is the only ISA in our sample where partnerships with older dwellers have been built. These have successfully bridged the cognitive and emotional distance between services integration programs and the lifeworlds of older dwellers. In the other rural ISAs, more can and should be done to involve older people. But also in urban ISAs, the challenge is to put to use older people’s talents and skills in order to support each other, other informal carers, and care professionals, and to increase social contacts with immigrant neighbors. Recent research in the city of Rotterdam has shown that it is not easy to establish such connections, as the different actors tend to stick to their own goals and ambitions (Van Dijk, 2015). Hopefully, in the long run, continuing efforts help to restore older people’s sense of ownership of transforming urban neighborhoods.

Finally, this research has pointed out that in small rural communities like Zeevang, where program management fell apart and accessibility problems persist,

integrating services “from above” is very difficult. Yet, citizen initiatives to support aging in place based on insideness and reciprocity have emerged precisely in these places (Horsten, 2008). Municipalities could facilitate these initiatives by providing the necessary funding and staff to develop elements of ISAs that fit with the needs for care and support of recipients and providers of informal care.

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